c. A change in ownership of a hospice is not considered a change in the patient's designation of a hospice, and requires no action on the patient's part. (10-24-88)

07. Requirements for Coverage. To be covered, a certification that the individual is terminally ill must have been completed as set forth in Idaho Health and Welfare Department Rules Section 104.02 and hospice services must be reasonable and necessary for the palliation and management of the terminal illness and related conditions. The individual must elect hospice care in accordance with Idaho Health and Welfare Department Rules Section 104.03 and a plan of care must be established and reviewed at least monthly. To be covered, services must be consistent with the plan of care. (7-1-94)

a. In establishing the initial plan of care, the member of the basic interdisciplinary group who assesses the patient's needs must meet or call at least one (1) other group member (nurse, physician, medical social worker, or counselor) before writing the initial plan of care. At least one (1) of the persons involved in developing the initial plan must be a nurse or a physician. This plan must be established on the same day as the assessment if the day of assessment is to be a covered day of hospice care. The other two (2) members of the basic interdisciplinary group must review the initial plan of care and provide their input to the process of establishing the plan of care within two (2) calendar days following the day of assessment, input may be provided by telephone. (10-24-88)

08. Required Services. All services must be performed by appropriately qualified personnel, but it is the nature of the service, rather than the qualification of the person who provides it, that determines the category of the service. The following services are required: (10-24-88)

a. Nursing care provided by or under the supervision of a registered nurse. (10-24-88)

b. Medical social services provided by a social worker who has at least a bachelor's degree from a school accredited or approved by the Council on Social Work Education, and who is working under the direction of a physician. (10-24-88)

c. Physician's services performed by a physician as defined in Idaho Health and Welfare Department Rules Section 104.01.a. (7-1-94)

d. Counseling services provided to the terminally ill individual and the family members or other persons caring for the individual at home. Counseling, including bereavement and dietary counseling, are core hospice services provided both for the purpose of training the individual's family or other care-giver to provide care, and for the purpose of helping the individual and those caring for him or her to adjust to the individual's approaching death. (10-24-88)

e. Short-term inpatient care provided in a participating hospice inpatient unit, or a participating hospital, or a NF that additionally meets the hospice standards regarding staff and patient areas. Services provided in an inpatient setting must conform to the written plan of care. General inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management which cannot be provided in other settings. Inpatient care may also be furnished to provide respite for the individual's family or other persons caring for the individual at home. (7-1-94)

f. Medical equipment and supplies include drugs and biologicals. Only drugs as defined in Subsection 1861(t) of the Social Security Act and which are used primarily for the relief of pain and symptom control related to the patient's terminal illness are required. Appliances include durable medical equipment as well as other self-help and personal comfort items related to the palliation or management of the patient's terminal illness. Equipment is provided by the hospice for use in the patient's home while he or she is under

hospice care. Medical supplies include only those that are part of the written plan of care. (7-1-94)

g. Home health aide and homemaker services furnished by qualified aides. Home health aides will provide personal care services and will also perform household services necessary to maintain a safe and sanitary environment in areas of the home used by the patient. Aide services must be provided under the general supervision of a registered nurse. Homemaker services include assistance in maintenance of a safe and healthy environment and services to enable the individual to carry out the plan of care. (10-24-88)

h. Physical therapy, occupational therapy and speech-language pathology services provided for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills. (10-24-88)

i. Nursing care, physician's services, medical social services and counseling are core hospice services and must be routinely provided by hospice employees. Supplemental core services may be contracted for during periods of peak patient loads and to obtain physician specialty services. (10-24-88)

09. Hospice Reimbursement--General. With the exception of payment for physician services (see Idaho Health and Welfare Department Rules Section 104.11), Medicaid reimbursement for hospice care will be made at one (1) of four (4) predetermined rates for each day in which an individual receives the respective type and intensity of the services furnished under the care of the hospice. The four (4) rates are prospective rates; there will be no retroactive rate adjustments other than the application of the "cap" on overall payments and the limitation on payments for inpatient care, if applicable. (7-1-94)

a. A description of the payment for each level of care is as follows: (10-24-88)

i. Routine home care. The hospice will be paid the routine home care rate for each day the patient is in residence, under the care of the hospice, and not receiving continuous home care. This rate is paid without regard to the volume or intensity of routine home care services provided on any given day. (10-24-88)

ii. Continuous home care. Continuous home care is to be provided only during a period of crisis. A period of crisis is a period in which a patient requires continuous care which is primarily nursing care to achieve palliation and management of acute medical symptoms. Care must be provided by either a registered nurse or a licensed practical nurse and a nurse must provide care for at least half the total period of care. A minimum of eight (8) hours of care must be provided during a twenty-four (24) hour day which begins and ends at midnight. This care need not be continuous and uninterrupted. If less skilled care is needed on a continuous basis to enable the person to remain at home, this is covered as routine home care. For every hour or part of an hour of continuous care furnished, the hourly rate will be reimbursed to the hospice up to twenty-four (24) hours per day. (10-24-88)

iii. Inpatient respite care. The hospice will be paid at the inpatient respite care rate for each day that the recipient is in an approved inpatient facility and is receiving respite care. Payment for respite care may be made for a maximum of five (5) days at a time including the date of admission but not counting the date of discharge in any monthly election period. Payment for the sixth and any subsequent day is to be made at the appropriate rate routine, continuous, or general inpatient rate. (10-24-88)

iv. General inpatient care. Payment at the inpatient rate will be made when general inpatient care is provided. No other fixed payment rates will be applicable for a day on which the recipient receives hospice general

inpatient care except as described in Idaho Health and Welfare Department Rules Section 104.11. (7-1-94)

b. Date of discharge. For the day of discharge from an inpatient unit, the appropriate home care rate is to be paid unless the patient dies as an inpatient. When the patient is discharged as deceased, the inpatient rate, either general or respite, is to be paid for the discharge date. (10-24-88)

c. Hospice payment rates. The Medicaid hospice payment rates are the same as the Medicare hospice rates, adjusted to disregard cost offsets attributable to Medicare coinsurance amounts. Under the Medicaid hospice benefit, no cost sharing may be imposed with respect to hospice services rendered to Medicaid recipients. (10-24-88)

d. Obligation of continuing care. After the recipient's hospice benefit expires, the patient's Medicaid hospice benefits do not expire. The hospice must continue to provide that recipient's care until the patient expires or until the recipient revokes the election of hospice care. (10-24-88)

10. Limitation on Payments for Inpatient Care. Payments to a hospice for inpatient care must be limited according to the number of days of inpatient care furnished to Medicaid patients. During the twelve (12) month period beginning November 1 of each year and ending October 31 of the next year, the aggregate number of inpatient days (both general inpatient days and inpatient respite care) may not exceed twenty percent (20%) of the total number of days of hospice care provided to all Medicaid recipients during the same period by the designated hospice or its contracted agent(s). (10-24-88)

a. For purposes of computation, if it is determined that the inpatient rate should not be paid, any days for which the hospice receives payment at a home care rate will not be counted as inpatient days. The limitations on payment for inpatient days are as follows: (10-24-88)

i. The maximum number of allowable inpatient days will be calculated by multiplying the total number of a provider's Medicaid hospice days by twenty percent (20%). (10-24-88)

ii. If the total number of days of inpatient care to Medicaid hospice patients is less than or equal to the maximum number of inpatient days computed in Idaho Health and Welfare Department Rules Section 104.10.a, then no adjustment is made. (7-1-94)

iii. If the total number of days of inpatient care exceeds the maximum number of allowable inpatient days computed in Idaho Health and Welfare Department Rules Section 104.10.a, then the payment limitation will be determined by: (7-1-94)

(a) Calculating the ratio of the maximum allowable inpatient days to the number of actual days of inpatient care, and multiplying this ratio by the total reimbursement for inpatient care that was made. (10-24-88)

(b) Multiplying excess inpatient care days by the routine home care rate. (10-24-88)

(c) Adding the amounts calculated in paragraphs (a) and (b). (10-24-88)

(d) Comparing the amount in paragraph (c) with interim payments made to the hospice for inpatient care during the "cap period." (10-24-88)

b. The amount by which interim payments for inpatient care exceeds the amount calculated as in Idaho Department of Health and Welfare Rules Section 104.10.a.iii.(d) is due from the hospice. (7-1-94)

11. Payment for Physician Services. The basic rates for hospice care represent full reimbursement to the hospice for the costs of all covered services related to the treatment of the recipient's terminal illness, including the administrative and general activities performed by physicians who are employees of or working under arrangements made with the hospice. These activities would generally be performed by the physician serving as the medical director and the physician member of the hospice interdisciplinary group. Group activities include participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care, and establishment of governing policies. The costs for these services are included in the reimbursement rates for routine home care, continuous home care, and inpatient respite care. (10-24-88)

a. Reimbursement for a hospice employed physician's direct patient services which are not rendered by a hospice volunteer is made in accordance with the usual Idaho Medicaid reimbursement methodology for physician services. These services will be billed by the hospice under the hospice provider number and, the related payments will be counted in determining whether the overall hospice cap amount per Idaho Health and Welfare Department Rules Section 104.12. has been exceeded. The only physician services to be billed by a hospice for such services are direct patient care services. Laboratory and X-ray services are included in the hospice daily rate. (7-1-94)

b. Volunteer physician services are excluded from Medicaid reimbursement with the following exceptions: (10-24-88)

i. A hospice may be reimbursed on behalf of a volunteer physician for specific direct patient care services which are not rendered on a volunteer basis. The hospice must have a liability to reimburse the physician for those services rendered. In determining whether a service is provided on a volunteer basis, a physician must not distinguish which services are provided voluntarily on the basis of the patient's ability to pay. (10-24-88)

ii. Reimbursement for an independent physician's direct patient services which are not rendered by a hospice volunteer is made in accordance with the usual Idaho Medicaid reimbursement methodology for physician services. These services will not be billed by the hospice under the hospice provider number and they will not be counted in determining whether the overall hospice cap amount per Idaho Health and Welfare Department Rules Section 104.12. has been exceeded. The only services to be billed by an attending physician are the physician's personal professional services. Costs for services such as laboratory or X-rays are not to be included on the attending physician's billed charges to the Medicaid program. The aforementioned charges are included in the daily rates paid and are expressly the responsibility of the hospice. (7-1-94)

12. Cap on Overall Reimbursement. Aggregate payments to each hospice will be limited during a hospice cap period per Idaho Health and Welfare Department Rules Section 104.01.e. The total payments made for services furnished to Medicaid recipients during this period will be compared to the "cap amount" for this period. Any payments in excess of the cap must be refunded by the hospice. (7-1-94)

a. The overall cap will be compared to reimbursement after the inpatient limitation is computed and subtracted from total reimbursement due the hospice. (10-24-88)

b. "Total payment made for services furnished to Medicaid recipients during this period" means all payments for services rendered during the cap year, regardless of when payment is actually made. (10-24-88)

c. The "cap amount" is calculated by multiplying the number of recipients electing certified hospice care during the period by six thousand five hundred dollars ($6,500). This amount will be adjusted for each subsequent cap year beginning November 1, 1983, to reflect the percentage increase

or decrease in the medical care expenditure category of the Consumer Price Index (CPI) for all urban consumers as published by the Bureau of Labor Statistics. It will also be adjusted as per Idaho Health and Welfare Rules Section 104.13. (7-1-94)

d. The computation and application of the "cap amount" is made by the Department after the end of the cap period. (10-24-88)

e. The hospice will report the number of Medicaid recipients electing hospice care during the period to the Department. This must be done within thirty (30) days after the end of the cap period as follows: (10-24-88)

i. If the recipient is transferred to a noncertified hospice no payment to the noncertified hospice will be made and the certified hospice may count a complete recipient benefit period in their cap amount. (10-24-88)

f. If a hospice certifies in mid-month, a weighted average cap amount based on the number of days falling within each cap period would be used. (10-24-88)

13. Adjustment of the Overall Cap. Cap amounts in each hospice's cap period will be adjusted to reflect changes in the cap periods and designated hospices during a recipient's election period. The proportion of each hospice's days of service to the total number of hospice days rendered to the recipient during their election period will be multiplied by the cap amount to determine each hospice's adjusted cap amount. (6-23-89)

a. After each cap period has ended, the Department will calculate the overall cap within a reasonable time for each hospice participating in the Idaho Medicaid Program. (10-24-88)

b. Each hospice's cap amount will be computed as follows: (10-24-88)

i. The share of the "cap amount" that each hospice is allowed will be based on the proportion of total covered days provided by each hospice in the "cap period". (6-23-89)

ii. The proportion determined in Idaho Health and Welfare Department Rules Section 104.13.b. for each certified hospice will be multiplied by the "cap amount" specified for the "cap period" in which the recipient first elected hospice. (7-1-94)

c. The recipient must file an initial election during the period beginning September 28 of the previous year through September 27 of the current cap year in order to be counted as an electing Medicaid recipient during the current cap year. (6-23-89)

14. Additional Amount for NF Residents. An additional per diem amount will be paid for "room and board" of hospice residents in a certified NF receiving routine or continuous care services. In this context, the term "room and board" includes, but is not limited to, all assistance in the activities of daily living, in socializing activities, administration of medication, maintaining the cleanliness of a resident's room, and supervision and assisting in the use of durable medical equipment and prescribed therapies. The additional payments and the related days are not subject to the caps specified in Subsections 104.10. and 104.12. The room and board rate will be ninety-five percent (95%) of the per diem interim reimbursement rate assigned to the facility for those dates of service on which the recipient was a resident of that facility. (7-1-94)

105. HOME HEALTH SERVICES. (4-1-91)

01. Care and Services Provided. Home health services encompass services ordered by the patient's attending physician as a part of a plan of

care, which include nursing services, home health aide, physical therapy and occupational therapy. (4-1-91)

a. All plans of care must be reviewed by the patient's physician at least every sixty (60) days; and (11-10-81)

b. The need for medical supplies and equipment ordered by the patient's physician as required in the care of the patient and suitable for use in the home must be reviewed at least once every sixty (60) days. (7-15-87)

c. Home health visits are limited to one hundred (100) visits per calendar year per person. (11-10-81)

d. Payment by the Department for home health services will include mileage as part of the cost of the visit. (11-10-81)

02. Provider Eligibility. In order to participate as a Home Health Agency (HHA) provider for Medicaid eligible persons, the provider must be licensed as required by the state, and be certified to participate in the Medicare Program. Loss of either state license or Medicare Program certification will be cause for termination of Medicaid provider status. (7-15-87)

03. Payment Procedures. Payment for home health services will be limited to the services authorized in Subsection 105.01. and must not exceed the lesser of reasonable cost as determined by Medicare or the Title XIX percentile cap. (12-31-91)

a. For visits performed in the first state fiscal year for which this subsection is in effect, the Title XIX percentile cap will be established at the one hundred eighth percentile of the ranked costs per visit as determined by the Department using the data from the most recent finalized Medicare cost reports on hand in the Bureau on June 1, 1987. Thereafter the percentile cap will be revised annually, effective at the beginning of each state fiscal year. Revisions will be made using the data from the most recent finalized Medicare cost reports on hand thirty (30) days prior to the effective date. (5-5-93)

b. When determining reasonable costs of rented medical equipment ordered by a physician and used for the care of the patient the total rental cost of a Durable Medical Equipment (DME) item shall not exceed one-twelfth (1/12) of the total purchase price of the item. A minimum rental rate of fifteen dollars ($15) per month is allowed on all DME items. (5-1-92)

c. The Department may enter into lease/purchase agreements with providers in order to purchase medical equipment when the rental charges total the purchase price of the equipment. (11-10-81)

d. The Department will not pay for services at a cost in excess of prevailing Medicare rates. (11-10-81)

e. If a person is eligible for Medicare, all services ordered by the physician will be purchased by Medicare, except for the deductible and coinsurance amounts which the Department will pay. (11-10-81)

106. DURABLE MEDICAL EQUIPMENT AND MEDICAL SUPPLIES. The Department will purchase or rent medically necessary durable medical equipment and medical supplies for recipients residing in community settings. It will also purchase or rent equipment and supplies provided as a part of a home health agency plan of care and which meet the requirements found in Subsections 105.01. and 105.02. No payment will be made for any recipient's DME or medical supplies while such an individual is an inpatient in a hospital NF,or ICF/MR facility as such items are included in the per diem payment. (10-22-93)

01. Required Physician Orders. DME/medical supplies will be purchased only if ordered in writing by a physician with all of the following information written on the Department's designated form or other approved document. Such information must be attached to, or on file with, the Department for each claim submitted prior to payment authorization: (10-1-91)

a. The recipient's medical diagnosis and the current information on the medical condition which requires the use of the supplies and/or medical equipment; and (10-1-91)

b. An estimate of the time period that the medical supply item will be necessary and frequency of use. As needed (PRN) orders shall not be accepted; and (10-1-91)

c. The signature of the prescribing physician and the date of the order; and (11-1-86)

d. For medical supplies, the type and quantity of supplies necessary must be identified; and (11-1-86)

e. A full description of the medical equipment requested. All modifications to a basic equipment item shall be supported by the attending physician's prescription; and (10-1-91)

f. The number of months the equipment will be needed and the recipient's prognosis; and (10-1-91)

g. Oxygen and oxygen-related equipment require additional information (see Section 107.). (12-31-91)

02. Program Requirements -- DME. All claims for durable medical equipment must be prior authorized by the Department, except for the following items: (10-1-91)

a. Items which do not require prior authorization have a charge of one hundred dollars ($100) or less and include the following: (10-31-89)

i. Walkers, canes and crutches; and (10-31-89)

ii. Grab bars, toilet seat extenders and hand-held showers; and (10-31-89)

iii. Sliding boards and bath benches/chairs; and (10-31-89)

iv. Equipment for the treatment of decubitus ulcers as listed in Subsection 106.02.f.xviii. (10-22-93)

b. Equipment will be rented unless the Department decides that it would be more cost effective to purchase it. All rentals require prior authorization by the Department. (10-22-93)

c. Rental payments, including intermittent payments, shall automatically be applied to the purchase of the equipment. When rental payments equal the purchase price of the equipment, ownership of the equipment shall pass to the Department. (10-1-91)

d. No reimbursement will be made for the cost of materials covered under the manufacturer's warranty. If the warranty period has expired, information on file must include the date of purchase and warranty period. In addition, the Department shall require the following minimum warranty periods: (10-1-91)

i. A power drive wheelchair shall have a one (1) year warranty period; (10-22-93)

ii. An ultra light wheelchair shall have a lifetime warranty period; (10-22-93)

iii. An active duty lightweight wheelchair shall have a five (5) year warranty period; (10-22-93)

iv. All other wheelchairs shall have a one (1) year warranty period; (10-22-93)

v. All electrical components and new or replacement parts shall have a six (6) month warranty period; (10-1-91)

vi. All other DME not specified above shall have a one (1) year warranty period; (10-1-91)

vii. If the manufacturer denies the warranty due to user misuse/abuse, that information shall be forwarded to the Department at the time of the request for repair or replacement; (10-1-91)

viii. The monthly rental payment shall include a full service warranty. All routine maintenance, repairs, and replacement of rental equipment is the responsibility of the provider; (10-22-93)

e. Any equipment purchased will remain the property of the Department and return of the equipment to the Department may be required at such time as: (11-1-86)

i. The recipient is no longer eligible for MA; or (11-1-86)

ii. The recipient no longer requires the use of the equipment; or (11-1-86)

iii. The recipient expires. (10-1-91)

f. Covered equipment is limited to the following listed items: (11-1-86)

i. Apnea or cardiac monitors/alarms; and (11-1-86)

ii. CPAP machines; and (10-29-92)

iii. Commode chairs and toilet seat extenders; and (11-1-86)

iv. Crutches and canes; and (11-1-86)

v. Electronic bone growth stimulators; and (11-1-86)

vi. Equipment used for home dialysis including necessary water treatment equipment; and (11-1-86)

vii. Grab bars for the bathroom adjacent to the toilet and/or bathtub; and (11-1-86)

viii. Hand-held showers; and (11-1-86)

ix. Home blood glucose monitoring equipment; and (11-1-86)

x. Hospital beds, mattresses, trapeze bars, and side rails; and (11-1-86)

xi. Intravenous infusion pumps, insulin infusion pumps, and/or NG tube feeding pumps; and (10-31-89)

xii. IPPB machines, hand-held nebulizers and manual or electric percussors; and (10-31-89)

xiii. Oxygen concentrators; and (11-1-86)

xiv. Pacemaker monitors; and (11-1-86)

xv. Respirators, compressors and breathing circuit humidifiers; and (11-1-86)

xvi. Sliding boards and bath benches/chairs; and (11-1-86)

xvii. Suction pumps; and (11-1-86)

xviii. Equipment for the treatment or prevention of decubitus ulcers, such as foam or gel pads, sheep skins, etc.; and (11-1-86)

xix. Transcutaneous and/or neuromuscular electric nerve stimulators; and (11-1-86)

xx. Walkers; and (11-1-86)

xxi. Wheelchairs, manual and electric; and (10-31-89)

xxii. Electric or hydraulic patient lift devices designed to transfer a person to and from bed or bathtub, but excluding lift chairs, devices attached to motor vehicles and wall-mounted chairs which lift persons up and down stairs; and (10-31-89)

xxiii. Bilirubin lights; and (10-31-89)

xxiv. Medically necessary protective head gear; and (10-31-89)

xxv. Home traction equipment; and (10-31-89)

xxvi. Daily medication dose organizer. (10-31-89)

g. The total monthly rental cost of a DME item shall not exceed one-twelfth (1/12) of the total purchase price of the item. A minimum rental rate of fifteen dollars ($15) per month is allowed on all DME items. (10-1-91)

03. Coverage Conditions. Coverage of the following items is limited to the circumstances identified: (10-1-91)

a. The Department will provide the least costly wheelchair which is appropriate for the recipient's medical needs. The Department will authorize one (1) wheelchair per recipient not more often than once every five (5) years in accordance with the following criteria: (10-1-91)

i. In addition to the physician's information, each request for a wheelchair must be accompanied by a written evaluation by a physical therapist or an occupational therapist which includes documentation of the appropriateness and cost effectiveness of the wheelchair and its ability to meet the recipient's long-term medical needs; (10-1-91)

ii. Wheelchairs will be authorized according to the following criteria: (10-1-91)

(a) A manual wheelchair will be authorized based on the recipient's medical need. The recipient must be nonambulatory or have severely limited mobility and require a mobility aid to participate in normal daily activities; (10-1-91)

(b) A standard wheelchair will be authorized if the recipient's condition is such that the alternative would be confinement to a chair or bed; (10-1-91)

(c) A standard lightweight wheelchair will be authorized if the recipient's condition is such that he cannot propel a standard weight wheelchair and the alternative would be confinement to a chair or bed; (10-1-91)

(d) An ultra light weight wheelchair will be authorized if the recipient's conditions are such that he cannot propel a lightweight or standard weight wheelchair, and it is a last resort before considering a power driven wheelchair. (10-29-92)

b. Electric wheelchairs are purchased only if the recipient's medical needs cannot be met by a less costly means of mobility. The attending physician must certify that the power drive wheelchair is a safe means of mobility for the recipient and all of the following criteria are met: (10-1-91)

i. The recipient is permanently disabled as indicated by the attending physician; and (11-1-86)

ii. The disability is identified by the physician to be such that because of severe upper extremity weakness or lack of function, the recipient cannot operate any manual wheelchair. (10-1-91)

c. The Department will authorize repairs or the replacements of parts for wheelchairs including, but not limited to, the replacement of tires, footplates, seating systems, drive belts, and joysticks. The Department will repair or replace any of the above listed parts no more than once every twelve (12) months. In addition, nonemergency repairs totaling over two hundred dollars ($200) for manual wheelchairs and five hundred dollars ($500) for electric wheelchairs will require the submission of three (3) bids before authorization for payment can be approved. (10-22-93)

d. Specially designed seating systems for wheelchairs shall not be replaced more often than once every five (5) years. In addition, seating systems for recipients in expected growth stages shall provide for the enlargement of the system without the complete replacement of the system. (10-1-91)

e. Electric blood glucose testing devices are purchased only when: (11-1-86)

i. The recipient's eyesight is impaired to the point that color change in standard blood testing strips cannot be accurately detected; and (11-1-86)

ii. Such eyesight impairment is documented by the attending physician; or (10-31-89)

iii. The recipient's mental status is such that the recipient cannot be relied upon to accurately interpret test tape/tablet results as documented by the attending physician. (10-31-89)

iv. When there is medical documentation from the attending physician of insulin dependence with widely fluctuating blood sugars before meal time and/or frequent episodes of insulin reactions and/or evidence of frequent significant ketosis. (10-1-91)

v. When gestational diabetes has been documented by the attending physician and frequent monitoring of blood sugars is essential to adequately manage blood sugars during pregnancy. (10-1-91)

f. Electronic pain suppression/muscle stimulation devices are purchased only when the effectiveness of such devices is documented by the physician following a maximum of two (2) month trial period. The limitations of Subsection 106.03. apply. (10-22-93)